DOI: 10.1002/bco2.148

EDITORIAL

BJUI COMPASS

2022 May Editorial: 'The Unfair Reviewer Comments'

It is Spring Break, and I am travelling through Virginia to see family and visit law schools with my younger daughter. Springtime is interesting – it's sort of warm, but we had an impressive cold snap with snow and sub-freezing temperatures mixed with warmer weather – sort of a bring your ski jacket and shorts kind of trip. See Figures 1–5 for some Virginia scenery.

On the road trip, I enjoyed reading a thought-provoking tweet from a well-known academic urologist on the topic of reviewer comments from submitted articles for scholarly publications. What should you do when a reviewer gives feedback that is inaccurate, inflammatory, or perhaps just a biased point of view? My main message to take home is to encourage you to open a dialogue with the editor and/or associate editor when this happens. An editor should certainly read everything in reasonable detail that will be published, but it is impractical for the editor to read every submission and that is why there is a team of editors and ad hoc reviewers. You should certainly do your best to respond to reviewers' critiques point by point. You can make changes if feasible, but if not, then explain why. If a reviewer comment is unfair or inaccurate, it is reasonable to write to the editor on this specific point in addition to the standard revision letter. Editors want the process to be fair and incorporate these issues into reviewer training and selection.

I hope I piqued your curiosity enough to now want to keep reading and find out what the Tweet was all about. The tweeter only shared one reviewer comment that I have seen more than a few times: 'The manuscript needs to be revised by a native English language writer'. There were quickly >30 comments that mostly supported the tweeter's disappointment with the comment plus interesting responses saying they had received similar feedback in the past. There is a lot to unpack here. First, the tweeter is a well-known academic urologist from a U.S. institution, and there are no foreign language issues involved. Why do reviewers commonly use this phrase? If there are only a few critiques along the lines of clarity of writing, a reviewer may just point those out. There are certainly submitted papers that have significant writing problems, but the science of the paper looks good. Usually, reviewers use this phrase to communicate to the editorial team that they want the paper published, but it needs more copy editing – too much to list every instance. There are probably better phrases reviewers can use such as 'needs further editing by professional scientific writers'. We have such services at my institution and, although I have learned many of their writing tricks, there is probably no paper that could be sent to this group that would not be returned with an impressive number of track changes to navigate. We are probably talking about two different issues – opinions on clarity of writing, and true issues with authors limited in English writing skills. I must admit, for the latter, we are not seeing this very often – many institutions are realizing that clarity in writing is an important part of submitting to a highly competitive journal, and most submissions these days are well edited from the beginning.

If you are a reviewer, how much effort should you put into correcting grammar and syntax? Probably not a lot for an initial submission – mostly concentrating on the science and whether it is sound enough and/or competitive enough to be a good selection for a specific journal. If you are an editor, what should you do with highly critical or possibly inflammatory critiques? There are only a few choices: delete them, modify them, keep them in the letter and/or keep them in the letter with additional editorial board comments. There is probably not a rule for all situations. Most teams I have worked with deleted comments to authors on whether the reviewer votes to publish or not – those should be in the scoring and/or in the comments to editor.

As I have commented in past editorials, our reviewers are a voluntary work force, and they provide a significant service to our scientific publications. They do not always 'get it right', but in most cases, they help improve articles and/or decide which ones are highest priority. I think it is healthy to have these conversations – formally, and even when blowing off some steam on Twitter. We should always be respectful and thankful for our reviewers' time, expertise and efforts.

For the May 2022 BJUI Compass, we have eight papers from five different countries (no reviews this month).

To the Clinic… In our short history, we have a growing collection of articles focused on transperineal prostate biopsy. The article by Chen et al.[1] from Singapore focuses on the local anaesthesia technique. Using the Precision Point™ system, they studied 212 cases where a standard 12 core template was taken under local anaesthesia (i.e. not a saturation template). A consistent 0% sepsis rate was observed, and overall cancer detection rate was 64%, of which 84% were grade group 2 or higher. They compared with a historical cohort of transrectal techniques and have comparable overall and GG2 detection rates – including a 49% detection rate in anterior cores. The authors present additional data with MRI usage and biopsy/anaesthesia techniques.

The paper from Anton et al.[2] from Australia presents a 'real world' study of first line systemic therapy for metastatic castration-resistant prostate cancer (CRPC). They used an Australian database for capturing treatment events by disease state. The most common

FIGURE 1 Natural Bridge, Virginia. This impressive geological formation is 215 feet (65 m) high and 90 feet (27 m) wide – all formed from water movement from the James River. The history includes the fact that Thomas Jefferson (founder of the University of Virginia and the 3rd president of the United States) purchased this area of land for the equivalent of around 3 dollars

FIGURE 2 During the cold snap, an impressive array of icicles formed under the bridge. The park service had to close the pathways underneath for safety

three were enzalutamide (41%), docetaxel (28%) and abiraterone (17%). There were trends observed: (a) use of docetaxel associated with younger patients (opposite trend for enzalutamide and abiraterone); (b) more favourable time to treatment failure starting with enzalutamide; (c) more favourable time to treatment failure if CRPC interval was >12 months.

Shifting the 'real world' theme to benign prostatic hypertrophy, Lehner et al.[3] from Baylor College of Medicine (Houston, Texas) and the affiliated Michael E. DeBakey Veterans Affairs (VA) Medical Center performed a retrospective review of the prostatic urethral lift procedure in a veterans' hospital population. In 91 cases, there was a mean 41% decrease in post void residual – durable with 54 months follow-up. Maximum urinary flow rate improved an average of 32%. They included treatment of patients in retention and observed 61% became catheter free. They discussed the impact of their study as a more liberalized inclusion criteria (including more co-morbidities) with more bladder decompensation in the cohort.

Hegarty et al.[4] from Ireland present a study on their technique of Peyronie's disease correction. They compared cohorts having multiple plaque incision with/without a draft – the 'with graft' having greater deformity. They present curvature improvements, patient-reported measures and techniques to maintain erectile function. This is open access – so enjoy the nice surgical diagrams included.

To the Drawing Board… In a prospective, multi-institutional study from the United States, Taylor et al.[5] focused on the topic of changing patients from active surveillance (AS) to active treatment for prostate cancer. This is a comprehensive study of clinical and psychological

FIGURE 3 The water runs through the adjacent creeks but with icicles still in the shade

FIGURE 4 Spring road trip in the 'airstream' at a state park near Richmond, Virginia

factors. Of interest, changing from AS to treatment was more likely if the urologist initially recommended treatment. They also found that 31% changed to treatment without progression, while 4.7% remained on surveillance with progression. The authors discuss the importance of the urologists' initial recommendation, and the need for greater decision support for patients on AS. This is a high effort study with a participation rate for these phone interviews of 1139 patients and a lot of useful data for AS researchers.

Lockhart et al.[6] from Australia explored the topic of pre-radical cystectomy cardiopulmonary exercise testing. Comparing cystectomy cases with/without this approach, there was a minor delay of 15 days, but favourable outcomes including length of stay, readmission rates and important risk evaluation parameters for understanding morbidity/mortality. It's a small study, but the discussion around the anaerobic threshold is of interest and may point to further enhancements to this high morbidity operation. This is Dr. Lockhart's second Compass publication – welcome back.

Bryant et al.[7] present another multi-institutional effort from the United States that asked the question whether age affects outcomes of prostate cancer treated by radiation therapy. Using a cohort of >12 000 patients from a VA database, they could group patients below age 60, and by decade. They found that younger patients had

FIGURE 5 The classic shot from the Lincoln Memorial in Washington DC looking over the reflecting pool, Washington Monument, and the U.S. Capitol in the distance

inferior outcomes including 3-month PSA levels, PSA nadir and biochemical recurrence. The authors discuss this age topic in more detail and ponder why younger patients might have more aggressive disease.

To the Future… For our innovation paper, Koukourikis et al.[8] from South Korea present a small case series of retzius sparing radical prostatectomy – using the DaVinci single port platform. They demonstrate safety and acceptable perioperative outcomes. The article has helpful surgical images, including their 'hack' for bending some of the assistant devices to get past the challenging angles associated with this approach. We will post a video on this paper.

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REFERENCES

1. Chen KW, Pek G, Yufei Q, Toh PC, Kuek N, Lee JKC, et al. Comparing outcomes of transperineal to transrectal prostate biopsies performed under local anaesthesia. BJUI Compass. 2021;1–8. https://doi.org/10.1002/bco2.112
2. Anton A, Pillai S, Semira MC, Wong S, Shapiro J, Weickhardt A, et al. Real-world first-line systemic therapy patterns in metastatic castration-resistant prostate cancer. BJUI Compass. 2021;1–9. https://doi.org/10.1002/bco2.129
3. Lehner K, Popat S, Utech K, Taylor J, Brooks M, Jones J. Outcomes of prostatic urethral lift in a medically complex population at a veterans affairs hospital. BJUI Compass. 2021;1–6. https://doi.org/10.1002/bco2.126
4. Hegarty PK, O'Sullivan D, Hegarty PA, Zafirakis H. Multiple plaque incisions with or without grafting for Peyronie's disease. BJUI Compass. 2022;1–6. https://doi.org/10.1002/bco2.130
5. Taylor KL, Luta G, Zotou V, Lobo T, Hoffman RM, Davis KM, et al. Psychological predictors of delayed active treatment following active surveillance for low-risk prostate cancer: The patient REported outcomes for prostate cARE prospective cohort study. BJUI Compass. 2021;1–12. https://doi.org/10.1002/bco2.124
6. Lockhart KR, Carroll R, Tiu A, Blatt A. Does the introduction of preoperative cardiopulmonary exercise testing in radical cystectomy delay or alter surgical care? BJUI Compass. 2021;1–5. https://doi.org/10.1002/bco2.133
7. Bryant AK, Nelson TJ, McKay RR, Kader AK, Parsons JK, Einck JP, et al. Impact of age on treatment response in men with prostate cancer treated with radiotherapy. BJUI Compass. 2021;1–8. https://doi.org/10.1002/bco2.132
8. Koukourikis P, Alqahtani AA, Han WK, Rha KH. Pure single-port retzius-sparing robot-assisted radical prostatectomy with the da Vinci SP: Initial experience and technique description. BJUI Compass. 2022;1–6. https://doi.org/10.1002/bco2.131